

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06301

Reg. Dist. No... 290

1. PLACE OF DEATH COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>		COUNTY <i>Talbot</i>		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Easton</i>		LENGTH OF STAY (in this place) <i>50 yrs.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Easton</i>		STREET ADDRESS <i>Aurora St.</i>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS						(If rural, give location)		
3. NAME OF DECEASED (Type or Print)		(First) <i>Mary</i>	(Middle) <i>Dawson</i>	(Last) <i>Edkins</i>	4. DATE OF DEATH	(Month) <i>June</i>	(Day) <i>28</i>	(Year) <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGER, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>Nov. 26, 1861</i>	9. AGE last birthday <i>89</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Talbot, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>A.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Name keeper</i>		16. SOCIAL SECURITY NO. <i>✓</i>		17. INFORMANT <i>Miss Edith Adkins</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Cornelius Parrott</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>				
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH								
Immediate cause <i>H20.0</i>		(a) <i>Arteriosclerotic Heart Disease</i>						
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause <i>93d</i>		(b) <i>Arteriosclerosis, generalized</i>				<i>- yes?</i>		
(c)								
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)		
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <input type="checkbox"/> m. <input type="checkbox"/> Work <input type="checkbox"/> At work <input type="checkbox"/>				
22. I hereby certify that I attended the deceased from <i>1946</i> , to <i>6/28/1957</i> , that I last saw the deceased alive on <i>6/28/1957</i> , and that death occurred at <i>10:30 a.m.</i> , from the causes and on the date stated above.								
SIGNATURE <i>Mr. Lov</i>		(Degree or title) <i>m.d.</i>		ADDRESS <i>Easton, Md.</i>		DATE SIGNED <i>6/29/57</i>		
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <i>June 30, 1957</i>		NAME OF CEMETERY OR CREMATORIAL <i>Albemarle</i>		LOCATION (City, town, or county) <i>Easton</i>		
DATE REC'D BY LOCAL REG. <i>6/29/57</i>		REGISTRAR'S SIGNATURE <i>N.H. Neerius</i>		24. FUNERAL DIRECTOR <i>Robert</i>		ADDRESS <i>Easton, Md.</i>		



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06302

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
4. SEX	5. COLOR OR RACE	6. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	7. DATE OF BIRTH
Female	White	MARRIED	1913/09/13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
at home	at home	Md. (Baltimore)	USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
John B. Hess	Annie M. Barnstable	No	
16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS	18. MEDICAL CERTIFICATION	
66-12345	My Charles Alhoff	Myocarditis Coronary Thrombosis Atherosclerotic Disease	
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause 4420.1	(a)	INTERVAL BETWEEN ONSET AND DEATH 14 hours	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93e	(b)	17 days	
	(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 24, 1951</u> , to <u>June 8, 1951</u> , that I last saw the deceased alive on <u>June 8, 1951</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>M. V. Palmer</u> (Degree or title) ADDRESS DATE SIGNED <u>6/12/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>6/11/51</u>	NAME OF CEMETERY OR CREMATORIAL <u>St. Peter's</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTER'S SIGNATURE <u>H. H. Neerius</u>	24. FUNERAL DIRECTOR ADDRESS <u>Boston Bus Cemetery Md.</u>	

RECEIVED

JUL 1 1951

BUREAU V. S.

06303

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 290

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY TALBOT		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY Cecilie	
CITY (If outside corporate limits, write RURAL and give nearest town) EASTON		CITY (If outside corporate limits, write RURAL and give nearest town) Federalsburg	
TOWN		STREET (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL Hospital			
3. NAME OF DECEASED (First) Roy		(Last) ARNEY	
(Middle)		4. DATE OF DEATH 6 28 1951	
(Type or Print)		5. SEX Male	
6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cecilie Co. Md		12. CITIZEN OF WHAT COUNTRY A.D.A.	
13. FATHER'S NAME John Frank Arney		14. MOTHER'S MAIDEN NAME Ella Todd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 222-00-9248	
17. INFORMANT J. J. Trampeter & Son		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

813.5

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

170 C**Automobile accident****Chest injury****Arteriosclerotic heart disease**INTERVAL BETWEEN
ONSET AND DEATH**4 days****4 days****Years**

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) hiway		(CITY OR TOWN) Federalsburg (COUNTY) Cecilie (STATE) Md
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED OF INJURY 6 24 51 c 9 p.m. While at work <input type="checkbox"/> Not while work <input type="checkbox"/> at work <input type="checkbox"/>
HOW DID INJURY OCCUR? struck by car while riding bicycle				

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident suicide , homicide , undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

6-28-51

23. BURIAL, CREMATION REMOVAL (Specify) Buried	DATE THEREOF 6/2/51	NAME OF CEMETERY OR CREMATORIAL Gill Creek	LOCATION (City, town, or county) Federalsburg (State) Md
DATE REC'D BY LOCAL REG. 6/29/51	REGISTRAR'S SIGNATURE N. H. Neerer	24. FUNERAL DIRECTOR J. J. Trampeter Son	ADDRESS Federalsburg Md.



RECEIVED

JUL 6 1951

C. E. V. G.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06304

Reg. Dist. No. 290

CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <i>Falbot</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Easton</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Oxford</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Easton Memorial Hosp.</i>		STREET ADDRESS <i>(If rural, give location)</i>	
3. NAME OF DECEASED (Type or Print) <i>Ezekiel</i>	(First)	(Middle)	(Last) <i>CORKran</i>
4. DATE OF DEATH <i>June 27 1951</i>	(Month)	(Day)	(Year)
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Jan 3 1878</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cameraman</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	9. AGE last birthday <i>73 yrs.</i>	11. BIRTHPLACE (State or foreign country) <i>Falbot Co Md</i>
12. CITIZEN OR WHAT COUNTRY <i>084</i>	13. FATHER'S NAME <i>Mr Charles Cokran</i>	14. MOTHER'S MADDEN NAME <i>Mary Neighbors</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>
16. SOCIAL SECURITY NO. <i>Unknown</i>	17. INFORMANT AND ADDRESS <i>Mrs Marcia R Cokran</i>	18. MEDICAL CERTIFICATION <i>Carcinoma of Liver</i>	19. INTERVAL BETWEEN ONSET AND DEATH <i>?</i>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <i>156.1</i>		(a) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause <i>46 f</i> stating the underlying cause last (b)	
		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i>1951</i>	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
21. ACCIDENT SUICIDE HOMICIDE <i>Recreational</i>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>Injury</i>	(CITY OR TOWN) <i>Easton</i>	(COUNTY) <i>MD</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>6-27-1951</i>	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>From a fall</i>	
22. I hereby certify that I attended the deceased from <i>6-1-1951</i> to <i>6-27-1951</i> , that I last saw the deceased alive on <i>6-27-1951</i> , and that death occurred at <i>11 A.m.</i> , from the causes and on the date stated above. SIGNATURE <i>B. Cox</i> (Degree or title) <i>MD</i> ADDRESS <i>Easton MD</i> DATE SIGNED <i>6/28/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>6/29/51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Oxford</i>	LOCATION (City, town, or county) <i>Oxford</i>
DATE REC'D BY LOCAL REG. <i>6/28/51</i>	REGISTRAR'S SIGNATURE <i>N.H. Neerius</i>	24. FUNERAL DIRECTOR <i>M. S. Sherman & Son</i>	ADDRESS <i>Easton MD</i>



MARYLAND STATE DEPARTMENT OF HEALTH

06305

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Talbot</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Easton</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Easton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <i>407 Queen St.</i> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <i>Jane</i>	(Middle) <i>Elliott</i>	4. DATE OF DEATH (Month) <i>June</i> (Day) <i>4</i> (Year) <i>1951</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i></i>	8. DATE OF BIRTH <i>Feb 26, 1880</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	9. AGE last birthday 71 yrs.
13. FATHER'S NAME <i>William B. Greenwood</i>		11. BIRTHPLACE (State or foreign country) <i>Talbot, Maryland</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		12. CITIZEN OF WHAT COUNTRY? <i>A. S.</i>	
16. SOCIAL SECURITY NO. <i>None</i>		14. MOTHER'S MAIDEN NAME <i>Mary Margaret Ellington</i>	
17. INFORMANT <i>Lorraine Elliott, Easton, Md.</i>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

Immediate cause

(a)

apoplexy

One week

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last

93d

(b)

14 . C . V . D .

6 months

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *3 - 5 -*, 19*51*, to *6 - 4 -*, 19*51*, that I last saw the deceased alive on *6 - 4 -*, 19*51*, and that death occurred at *12:50 p.m.*, from the causes and on the date stated above.

SIGNATURE *J. B. Cox*(Degree or title) *M.D.*ADDRESS *Easton, Md.*DATE SIGNED *6 - 7 - 51*

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF <i>June 7, 1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>Springfield Cemetery</i>	LOCATION (City, town, or county) <i>Easton</i>	(State) <i>Md.</i>
DATE REC'D BY LOCAL REG. <i>6/5/51</i>	REGISTRAR'S SIGNATURE <i>J. H. Morris</i>	24. FUNERAL DIRECTOR <i>John Beck</i>	ADDRESS <i>Easton, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

24 N. Charles Street, Baltimore

06476

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		Eaton MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Eaton Memorial Hosp	STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		(First) Mr. Howard (Middle) Flowers (Last)	4. DATE OF DEATH June 30 1957	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M	8. DATE OF BIRTH April 27, 1882	9. AGE last birthday 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)* Savvyng cashier		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Mr. Nathan L. Davis		14. MOTHER'S MAIDEN NAME Rebecca Wheeler		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT AND ADDRESS Mrs Nellie Flowers (Same)	
18. MEDICAL CERTIFICATION				
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				
Immediate cause (a) Cancer of the head & the Antecedent cause(s) (b) pancreas Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)				
Interval Between Onset and Death (?)				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) OF INJURY	(Day) m.	(Year) 1951	(Hour) Work <input type="checkbox"/> At work <input type="checkbox"/>	(STATE)
		HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 6/21, 1951, to 30 pm, 1957, that I last saw the deceased alive on 30 June, 1957, and that death occurred at 1:30 pm m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED Mrs. Nellie Flowers, Eaton, Maryland 3 July 47				
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF July 3, 1951	NAME OF CEMETERY OR CREMATORIAL Greenmount	LOCATION (City, town, or county) Baltimore	(State)
DATE REC'D BY LOCAL REG. 7/1/51	REGISTRAR'S SIGNATURE M. A. Neiries	24. FUNERAL DIRECTOR ADDRESS George Woods, Jr. Dentist, Inc. 290716		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 17 1951

BUREAU X. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

D.O.A. 06306

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <i>Gibson</i> <i>Maryland, Talbot</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MD</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Talbot</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Easton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>None</i>		STREET ADDRESS <i>24 Port Street</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>William C.</i>	(Middle)	(Last) <i>Gibson</i>
4. DATE OF DEATH <i>June 13 1957</i>	(Month)	(Day)	(Year)
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M</i>	8. DATE OF BIRTH <i>Aug 14 1913</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Driver</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	9. AGE last birthday <i>37 yrs.</i>	11. BIRTHPLACE (State or foreign country) <i>England</i>
12. CITIZEN OF WHAT COUNTRY <i>USA</i>	13. FATHER'S NAME <i>William Gibson</i>	14. MOTHER'S MAIDEN NAME <i>Emma Blake</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>
16. SOCIAL SECURITY NO. <i>123-45-6789</i>	17. INFORMANT AND ADDRESS <i>Ella Gibson (wife) Same</i>	18. MEDICAL CERTIFICATION <i>Tuberculosis meningitis</i>	
INTERVAL BETWEEN ONSET AND DEATH <i>1 wk +</i>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause
010X

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last
14

(b)

Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last
14

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at 8:30 A.m., from the causes and on the date stated above.

SIGNATURE
Laird M. Nease MD(Degree or title)
*Surgeon*ADDRESS
*Easton Md*DATE SIGNED
6/13/57

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>6/15/57</i>	NAME OF CEMETERY OR CREMATORIAL <i>Richards</i>	LOCATION (City, town, or county) <i>Easton Md</i>	(State)
DATE REC'D. BY LOCAL REG. <i>6/14/57</i>	REGISTRAR'S SIGNATURE <i>N.H. Nease</i>	FUNERAL DIRECTOR <i>Herbert M. St. Clair Jr. Cambridge</i>	ADDRESS <i>W.M.D.</i>	

RECEIVED
BUREAU V. S.
JUN 19 1951

This patient
died on
the way
to Baltimore
Md

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06307

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY Talbot Co		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Eatontown		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chestertown		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eatontown Memorial Hospital		STREET ADDRESS		
3. NAME OF DECEASED (Type or Print)	(First) Mr. John Hall	(Middle)	(Last)	
4. DATE OF DEATH June 17	(Month)	(Day)	(Year) 1957	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M	8. DATE OF BIRTH Aug 29, 1907	
9. AGE last birthday 43	If under 1 year Months yrs.	If under 24 hrs. Days Hours	If under 24 hrs. Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>meat cutter</i>		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Mr. Robert Hall		14. MOTHER'S MADDEN NAME Anna Parks		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 7		
17. INFORMANT AND ADDRESS Mrs. Bessie Hall Jones		18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) Hodgkin's Disease Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last 446 (c)				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION 201X	19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>				
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work m. Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	<i>fall</i>	
22. I hereby certify that I attended the deceased from Aug. 1950, to 17 June 1951, that I last saw the deceased alive on 17 June 1951, and that death occurred at 7:30 a.m., from the causes and on the date stated above. SIGNATURE <i>John B. Hall</i> (Degree or title) ADDRESS <i>120 S. Main St.</i> DATE SIGNED <i>Aug. 18, 1951</i>				
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF 6/19/51	NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park	LOCATION (City, town, or county) Cambridge, Md.	(State)
DATE REC'D BY LOCAL REG. 6/18/51	REGISTRAR'S SIGNATURE <i>N. A. Neerius</i>	24. FUNERAL DIRECTOR ADDRESS Be Complete Funeral Service Cambridge, Md. 690406		

RECEIVED

JUN 25 1951

BUREAU V-5

06308

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

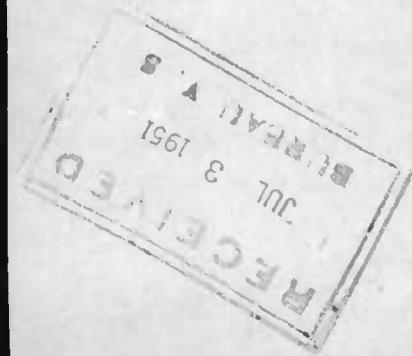
CERTIFICATE OF DEATH

Reg. Dist. No. 290

~~M~~ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
<i>Talbot</i> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		LENGTH OF STAY (in this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		(First) <i>LIZZIE</i>	(Middle) <i>HARRIS.</i>
4. DATE OF DEATH		(Month) <i>6</i>	(Day) <i>27</i>
		(Year) <i>1951</i>	
5. SEX		6. COLOR OR RACE	
FEMALE		NEGRO	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
Single		7 1880	
9. AGE last birthday yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
71		Housework	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Talbot Co. Md		U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Wilson		No Record.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		None	
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	
Isaac Mason			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <i>443X</i>		Years	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>93d</i>		Years	
(a) <i>DCVD</i>			
(b) <i>Blind & deaf</i>			
(c) <i>Blind & deaf</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> Not While Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
m.			
22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at <i>c 8A</i> m., from the causes and on the date stated above.		DATE SIGNED	
SIGNATURE <i>Louis Watty MD JME</i>		ADDRESS <i>Easton Md</i>	
23. BURIAL Cremation REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>JUNE 28 1951</i> NAME OF CEMETERY OR CREMATORY <i>In Town Cemetery</i> LOCATION (City, town, or county) <i>Easton (Rural) Md</i> (State) <i>6-28-51</i>	
DATE REC'D BY LOCAL REG. <i>6/28/51</i>		REGISTRAR'S SIGNATURE <i>N.H. Neerius</i> 24. FUNERAL DIRECTOR ADDRESS <i>Maurice E Newland & Son</i>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06309

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY Talbot		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Easton		LENGTH OF STAY IN this place 2 days	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Easton Memorial Hospital		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Preston, Md.	
STREET ADDRESS		If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) ENOS	(Middle)	(Last) HARVEY
4. DATE OF DEATH JUNE 3 1951	(Month)	(Day)	(Year)
5. SEX MALE	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH Oct 28 1870
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 80 yrs.	11. BIRTHPLACE (State or foreign country) Alabama
12. CITIZEN OF WHAT COUNTRY	13. FATHER'S NAME John Nease	14. MOTHER'S MAIDEN NAME Ann Monroe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 478-00-0000	17. INFORMANT AND ADDRESS Mr. Charles Payne, Jr.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Leprosy			
Antecedent cause(s) (b) Arterio Sclerotic Cardiac Disease			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 131a			
(c) C			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Oak arteries			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	INTERVAL BETWEEN ONSET AND DEATH 2 mos 7 days	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	5 yrs		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 6/10, 1951, to 6/3, 1951, that I last saw the deceased alive on 6/1, 1951, and that death occurred at 3:35 p.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED			
23. BURIAL, CREMATION REMOVED (Specify)	DATE THEREOF 6/5/51	NAME OF CEMETERY OR CREMATORIAL Hill Crest	LOCATION (City, town, or county) Federal Heights Md (State)
DATE REC'D BY LOCAL REG.	REGISTER'S SIGNATURE M. L. Nease	24. FUNERAL DIRECTOR ADDRESS 17 Orange Ave. Baltimore 4th Ward	

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06310

CERTIFICATE OF DEATH

Reg. Dist. No. 290

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE	
<i>Talbot.</i>		MARYLAND <i>Talbot.</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		LENGTH OF STAY (in this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		13 days	
3. NAME OF DECEASED (First) (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
17. <i>Hughett</i>		January 2 1951	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <i>March 30 1877</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		9. AGE last birthday 73 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <i>Polymoiles</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>John R. Hughett</i>		14. MOTHER'S MAIDEN NAME <i>Clara E. Kemp</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <i>Unknown</i>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>Immediate cause (a) <i>Cerebral Vascular Accident</i> 14 days</p> <p>Antecedent cause(s) (b) <i>Cerebral Arteriosclerosis</i> yrs.</p> <p>Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <i>Hypertensive Cardiovascular Disease</i> yrs.</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> Not While <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/49</i> , 19..., to <i>6/2</i> , 19 <i>51</i> , that I last saw the deceased alive on <i>6/2</i> , 19 <i>51</i> , and that death occurred at <i>11:12 P.M.</i> , from the causes and on the date stated above.			
SIGNATURE <i>Shayard Kuech Jr. M.D.</i>		(Degree or title) ADDRESS <i>Easton</i> DATE SIGNED <i>6/5/51</i>	
23. BURIAL/CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>June 5/51</i> NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <i>Springfield Cemetery</i> (State) <i>Talbot</i>	
DATE REC'D BY LOCAL REG. <i>6/3/51</i>		REGISTRAR'S SIGNATURE <i>N.H. Neerup</i> FUNERAL DIRECTOR ADDRESS <i>Manus Funeral Home</i>	
270906			

BUREAU U. S.

JUN 12 1951

RECORDED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06311

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH: COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR give nearest town TOWN <u>ST. MICHAELS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		LENGTH OF STAY (in this place) <u>LIFE</u>	
3. NAME OF DECEASED (Type or Print)		(First) <u>MARY</u>	(Middle) <u>M.</u>
4. DATE OF DEATH		(Last) <u>JACKSON</u>	(Month) <u>6</u> (Day) <u>1</u> (Year) <u>1951</u>
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic & own home.</u>	8. DATE OF BIRTH <u>Unknown</u>
13. FATHER'S NAME <u>John</u>		11. BIRTHPLACE (State or foreign country) <u>TALBOT - MARYLAND</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT AND ADDRESS <u>LAVINA MITCHELL - 40 MRS HARILAND</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Cardiac failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>One mo.</u>			
442X Antecedent cause(s) (b) <u>Arteriosclerotic cardio-vascular-renal</u> ? Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>disease</u>			
131a (c) <u>General debility with inanition.</u> 10 yrs			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? Not While <input type="checkbox"/>
22. I hereby certify that I attended the deceased from <u>D.O.A.: 19.....</u> , to <u>19.....</u> , that I last saw the deceased alive on <u>19.....</u> , and that death occurred at <u>4 10/12</u> m., from the causes and on the date stated above. SIGNATURE <u>St. Michaeland</u> (Degree or title) <u>ADDRESS P.O. 388</u> DATE SIGNED <u>6-2-51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6/4/51</u> NAME OF CEMETERY OR CREMATORIAL <u>St. Michaels</u> LOCATION (City, town, or county) <u>ST. MICHAELS - TALBOT - MD.</u> (State)	
DATE REC'D BY LOCAL REG. <u>June 3, 51</u>		REGISTRAR'S SIGNATURE <u>Mr. Robert L. Scott</u> 24. FUNERAL DIRECTOR ADDRESS <u>Norman D. Marshall</u> <u>St. Michaels, Md.</u>	
920826			

RECEIVED

JUN 6 1951

BUREAU N. 3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06312

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MD.</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Easton</i>		LENGTH OF STAY (in this place) <i>1 mo.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memorial Hospital</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS <i>Born in hospital Easton Died in hospital</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Baby girl</i>	(Middle) <i>Jacobs</i>	(Last)
4. SEX <i>F.</i>	6. COLOR OR RACE <i>Blach</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>single</i>	8. DATE OF BIRTH <i>June 5 1951</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	9. AGE last birthday yr. <i>11</i>	11. BIRTHPLACE (State or foreign country) <i>Md. (Memorial Hospital)</i>
13. FATHER'S NAME <i>James Green</i>	14. MOTHER'S MAIDEN NAME <i>Emily Jacobs</i>	12. CITIZEN OF WHAT COUNTRY? <i>Same</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT AND ADDRESS <i>Emily Jacobs (Same)</i>	18. MEDICAL CERTIFICATION <i>Cerebral Anoxia Placenta Previa (Mother)</i>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 761.0 Immediate cause (a) <i>Cerebral Anoxia</i> 160.0 Antecedent cause(s) (b) <i>Placenta Previa (Mother)</i> 160.0 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>12 hrs</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i>19b. MAJOR FINDINGS OF OPERATION</i>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>	(CITY OR TOWN) <i>(CITY OR TOWN)</i>	(COUNTY) <i>(COUNTY)</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>8 15 a.m.</i>	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> <i>m.</i>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>6-5, 1951</i> , to <i>6-6, 1951</i> , that I last saw the deceased alive on <i>6-6, 1951</i> , and that death occurred at <i>8 15 a.m.</i> , from the causes and on the date stated above. SIGNATURE <i>John E. Bayliss MD</i> ADDRESS <i>214 Dover St Easton MD</i> DATE SIGNED <i>6/16/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>6/6/51</i>	NAME OF CEMETERY OR CREMATORIUM <i>Cordova</i>	LOCATION (City, town, or county) <i>Cordova, Md.</i>
DATE REC'D BY LOCAL REG. <i>6/6/51</i>	REGISTRAR'S SIGNATURE <i>Nease</i>	24. FUNERAL DIRECTOR SIGNER <i>Garnet James Shore</i>	ADDRESS <i>Cordova, Md.</i>

206051990991

VS-A5

RECEIVED

JUL 1 1951

BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06313

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY Talbot Co		EASTON MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN EASTON, MD	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		EASTON MEMORIAL HOSP		STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		(First) <i>Pax.</i>	(Middle) <i>Henry</i>	(Last) <i>Kemp</i>	4. DATE OF DEATH		(Month) <i>June</i> (Day) <i>26</i> (Year) <i>1951</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>MARRIED</i>		8. DATE OF BIRTH <i>5/10/76</i>	9. AGE last birthday 75 yrs.		If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i> <i>mgr.</i>		11. BIRTHPLACE (State or territory, country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>A</i>	
13. FATHER'S NAME <i>Mr Hugh Kemp</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Freedman</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-03-3507</i>	
17. INFORMANT AND ADDRESS <i>Mrs Bessie Newell</i>							
18. MEDICAL CERTIFICATION							
INTERVAL BETWEEN ONSET AND DEATH							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause <i>420.0</i>		(a) <i>Cardiac failure, due to myocardial infarction, due to arteriosclerotic coronary thrombosis</i>					
Antecedent cause(s) <i>94a</i>		(b) <i>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</i>					
		(c) <i>Thrombosis</i>				<i>6 days</i>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>24 June</i> , 19 <i>51</i> , to <i>26 June</i> , 19 <i>51</i> , that I last saw the deceased alive on <i>26 June</i> , 19 <i>51</i> , and that death occurred at <i>10:30 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Hansha Hansen</i>		(Degree or title) <i>M.D.</i>		ADDRESS <i>Easton, Maryland</i>		DATE SIGNED <i>26 June 51</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>6/29/51</i>		NAME OF CEMETERY OR CREMATORIAL <i>Springfield</i>		LOCATION (City, town, or county) (State) <i>Easton, Md.</i>	
DATE REC'D. BY LOCAL REG. <i>6/27/51</i>		REGISTRAR'S SIGNATURE <i>H. J. Neelis</i>		24. FUNERAL DIRECTOR <i>M. & Son, Easton, Md.</i>		ADDRESS <i>100105</i>	



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06314

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Talbot				
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) TOWN Easton (In this place) 11 years				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Easton STREET ADDRESS (If rural, give location) Centreville Road				
3. NAME OF DECEASED (Type or Print)		(First) Wilson	(Middle) Thomas	(Last) Milligan	4. DATE OF DEATH	(Month) 6	(Day) 23	(Year) 1951
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year	If under 24 hrs.		
Male	White		Sept. 6, 1915	35 yrs.	Months	Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee Peoples Ice Co.				11. BIRTHPLACE (State or foreign country) Dorchester County, Maryland				
13. FATHER'S NAME Frank Milligan				12. CITIZEN OF WHAT COUNTRY? U.S.A.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes				16. SOCIAL SECURITY NO. 217-16-9590				
17. INFORMANT Mrs. Lena M. Milligan, Easton, Md.				18. MEDICAL CERTIFICATION				

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Suicide - G.S.W. head

INTERVAL BETWEEN
ONSET AND DEATH
Initial

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause

stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY 6 23 51 1951 m.	INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? GSW-head		

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide homicide , undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED
6-24-51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF June 26, 1951	NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery	LOCATION (City, town, or county) Easton, Maryland	(State)
DATE REC'D BY LOCAL REG. 6/24/51	REGISTRAR'S SIGNATURE N.H. Morris	24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Md.	ADDRESS 1101 419	

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06315

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u>		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>EASTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>EASTON</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print)	(First) <u>ALVERTA</u>	(Middle)	(Last) <u>MONROE</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH about 1894	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY, <u>CANNING House</u>	9. AGE last birthday If under 1 year Months Days Hours Min. 57 yrs.	
13. FATHER'S NAME <u>William FLAMER</u>		11. BIRTHPLACE (State or foreign country) <u>TALBOT County - Md.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
16. SOCIAL SECURITY NO. <u>020-03-5313</u>		17. INFORMANT AND ADDRESS <u>PAUL MONROE 504 Asbury PL. EASTON, Md.</u>		
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Acute Uremia, Hypertensive Heart Disease Immediate cause (a) _____ Antecedent cause(s) Arteriosclerotic Nephritis, Atheromatosis determined Disease or conditions, if any, giving rise to the above cause (b) _____ stating the underlying cause last (c) Senility				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None				
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION None	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE No (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) OF INJURY	(Hour) m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 15, 1951, to June 17, 1951, that I last saw the deceased alive on June 15, 1951, and that death occurred at 3 A.m., from the causes and on the date stated above. SIGNATURE <u>B. Nevers</u> (Degree or title) <u>M.D.</u> ADDRESS <u>St. Michaels, Md.</u> DATE SIGNED <u>6.18.51</u>				
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>6/19/51</u>	NAME OF CEMETERY OR CREMATORIAL <u>Chapel</u>	LOCATION (City, town, or county) (State) <u>Chapel, MARYLAND</u>	
DATE REC'D BY LOCAL REG. <u>6/19/51</u>	REGISTRAR'S SIGNATURE <u>N. H. Nevers</u>	24. FUNERAL DIRECTOR NORMAN D. MARSHALL ADDRESS <u>St. MICHAELS, Md.</u>		

RECEIVED

JUN 25 1951

BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06316

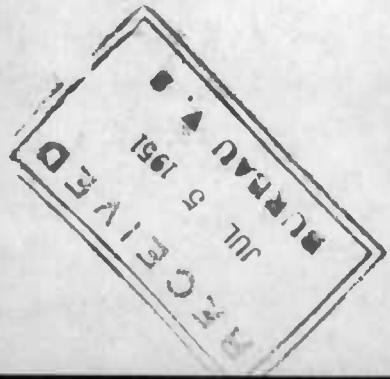
CERTIFICATE OF DEATH

Reg. Dist. No. 294

1. PLACE OF DEATH. COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>MARYLAND</u> COUNTY <u>TALBOT</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Mc DANIEL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mc DANIEL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)	(First) <u>FRANKLIN</u>	(Middle) <u>DONNELL</u>	(Last) <u>MURRAY</u>
4. SEX <u>MALE</u>	5. COLOR OR RACE <u>COLORED</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>SINGLE</u>	7. DATE OF BIRTH <u>2/26/39</u>
8. AGE last birthday <u>12</u> yrs.	9. IF under 1 year Months <u>4</u>	10. IF under 24 hrs. Days <u>7</u>	11. Hours <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Mc DANIEL Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>	13. FATHER'S NAME <u>WM Jos Henry Murray</u>		
14. MOTHER'S MAIDEN NAME <u>BERTHA Smith</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <u>BERTHA Smith</u>	
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>Accidental drowning</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>6 25 51</u>	19b. MAJOR FINDINGS OF OPERATION <u>HARRIS CK nr. McDaniel Tal. End</u>		
20. AUTOPSY? <input type="checkbox"/> Yes <input type="checkbox"/> No			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>accident</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TQWN) <u>HARRIS CK</u> (COUNTY) <u>Tal.</u> (STATE) <u>Md.</u>	
TIME (Month) <u>6</u> (Day) <u>25</u> (Year) <u>51</u> (Hour) <u>11</u> OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>acc. drowning while swimming</u>	
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above. SIGNATURE <u>Louis J. Kelly MD DMD Easton Md</u> (Degree or title) <u>CSP</u> ADDRESS <u>6-26-51</u> DATE SIGNED			
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>6/27/51</u>	NAME OF CEMETERY OR CREMATORIAL <u>CLAIBORNE, Md.</u>	LOCATION (City, town, or county) <u>CLAIBORNE - TALBOT - Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>June 27-51</u>	REGISTRAR'S SIGNATURE <u>G. Wesley Russell</u>	FUNERAL DIRECTOR <u>Norman D. MARSHALL</u>	ADDRESS <u>St. MICHAEL'S Md.</u>

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411, N. Charles Street, Baltimore

06317

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE	
Talbot Co		MARYLAND	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		LENGTH OF STAY (in this place)	
Easton, Md		13 day	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
Easton Memorial Hospital		Afrd, Md.	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Mr. Herbert Parrott		(Month) June	
(Middle)		(Day) 26	
(Last)		(Year) 1957	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
M	W	W	7-14-71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
one		none	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)	
Isaac Parrott		Md	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY	
No		USA	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME	
none		Sarah Gannon	
17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	
Mr. Reginald Parrott		Arteriosclerosis, generalized	
INTERVAL BETWEEN ONSET AND DEATH			
2 yrs?			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause		(a)	
Antecedent cause(s)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b)	
97			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?			
Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
m.		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 6-14, 1951, to 6/26/1951, that I last saw the deceased alive on 6/26/1951, and that death occurred at 7:50 P.M. from the causes and on the date stated above.			
SIGNATURE		(Degree or title) ADDRESS	
R. C. Co.		M. D. Easton, Md.	
DATE SIGNED			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	
Burial		6/29/51	
NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county)	
Spruce Hill		Easton, Md.	
(State)			
DATE REC'D BY LOCAL REG. 6/27/51		REGISTRAR'S SIGNATURE	
T. A. Nelson		24. FUNERAL DIRECTOR	
ADDRESS		ADDRESS	
Castor Rd.		Castor Rd.	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06318

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>EASTON</u>		LENGTH OF STAY (in this place) <u>ALLOFLITE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington St. Ext.</u>		STREET ADDRESS <u>Washington St. Ext.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ANNIE</u>	(Middle) <u>Emily</u>	(Last) <u>Patchett</u>
4. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>Nov. 22, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>CAROLINE Co. Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>SAMUEL JAMES</u>	14. MOTHER'S MAIDEN NAME <u>MARY Thomas</u>	9. AGE last birthday 76 yrs.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT AND ADDRESS <u>Mrs. Emma Upton BROOKLYN N.Y.</u>	18. MEDICAL CERTIFICATION <u>Carcinoma of Liver</u>
INTERVAL BETWEEN ONSET AND DEATH <u>6 month</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) 156.1

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last(b) 46 f

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from March, 1951, to 6/21/51, 1951, that I last saw the deceasedalive on 6/21/51, 1951, and that death occurred at 8 A.M. m., from the causes and on the date stated above.
SIGNATURE 13 Cox (Degree or title) Dr. ADDRESS EASTON 2nd DATE SIGNED 6/22/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6/23/51</u>	<u>Spring Hill</u>	<u>EASTON, Md.</u>

DATE REC'D BY LOCAL REG. #	REG. #	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>6/22/51</u>	<u>N.H. Neeris</u>		<u>MAURICE E NEWNAM & Son</u>	<u>EASTON, Md.</u>



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

P6319

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hillsboro</u>	
LENGTH OF STAY (in this place) <u>14 days -</u>		STREET ADDRESS <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>			
3. NAME OF DECEASED (Type or Print)	(First) <u>Pearl</u>	(Middle)	(Last) <u>Pinkney</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>18</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>?</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>?</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Will Brown</u>	14. MOTHER'S MAIDEN NAME <u>Sally Massey</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS <u>Ollie Pinkney</u>	18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <u>446X</u>	(a) <u>nephrosclerosis</u>	INTERVAL BETWEEN ONSET AND DEATH ?	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>131a</u>	(b) <u>arteriosclerosis, generalized</u>	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? DATE SIGNED	
22. I hereby certify that I attended the deceased from <u>6/4</u> , 19 <u>51</u> , to <u>6/18/</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>6/18/</u> , 19 <u>51</u> and that death occurred at <u>5:38 p.m.</u> , from the causes and on the date stated above. SIGNATURE <u>M. W. C.</u> ADDRESS <u>Easton Md</u> DATE SIGNED <u>6/19/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>June 20, 1951</u>	NAME OF CEMETERY OR CREMATORIAL <u>Burdettown Rd</u>	LOCATION (City, town, or county) (State) <u>Hillsboro Md</u>
DATE REC'D BY LOCAL REG. REG. <u>6/19/51</u>	REGISTRAR'S SIGNATURE <u>M. H. Neeris</u>	24. FUNERAL DIRECTOR ADDRESS <u>J. D. Engel, Moore & Son</u>	

RECEIVED
JUN 25 1951

DREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06320

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>CAROLINE</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Easton</u>		LENGTH OF STAY (in this place) <u>70 days</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		STREET ADDRESS <u>Ridgely, Md.</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Charles A. Rampmeyer</u>	(First) <u>Charles</u>	(Middle) <u>A.</u>	(Last) <u>Rampmeyer</u>
4. DATE OF DEATH <u>June 14 1951</u>	(Month) <u>June</u>	(Day) <u>14</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>18 yrs.</u>
9. AGE last birthday yrs. <u>18</u>	If under 1 year Months <u>0</u>	If under 24 hrs. Days <u>0</u>	If under 24 hrs. Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>August Rampmeyer</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Weber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Memorial Hospital - Easton Md</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) coronary Embolus
 Antecedent cause(s) (b) arteric sclerosis
 Diseases or conditions, if any, giving rise to the above cause (c) Hypertrophied prostate.
 137a stating the underlying cause last

INTERVAL BETWEEN
ONSET AND DEATH
1 hrII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION June 12, 1951 19b. MAJOR FINDINGS OF OPERATION Hard nodular fixed growth in prostate -

20. AUTOPSY?
Yes No

21. ACCIDENT (Specify) SUICIDE PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY (CITY OR TOWN) Easton (COUNTY) Md. (STATE) Md.

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED
OF INJURY June 14, 1951 While at Work Not While At work HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 4, 1951, to June 14, 1951, that I last saw the deceased alive on June 14, 1951, and that death occurred at 3:40 p.m., from the causes and on the date stated above.
SIGNATURE John F. Schneider, M.D. (Degree or title) Easton, Maryland DATE SIGNED June 15, 1951

23. BURIAL, CREMATION
REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)
Burial 6/17/51 Ridgely Ridgely, Md.
DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE N.H. Nease 24. FUNERAL DIRECTOR R.B. Rawlings ADDRESS Baltimore
6/15/51 5004/16 Md.

RECEIVED

JUL 1 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06321

CERTIFICATE OF DEATH

Reg. Dist. No... 294

1. PLACE OF DEATH COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>WITTMAN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bozman</u>	
LENGTH OF STAY (in this place) <u>6 years</u>		STREET ADDRESS <u>RURAL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		(If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>ROBERT</u>	(Middle) <u>T.</u>	(Last) <u>Scott</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Aug 1 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR <u>FARMING</u>	9. AGE last birthday <u>987</u> yrs.
13. FATHER'S NAME <u>Flurry Scott</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Robert T. Scott, Wittenman, Md.</u>		18. MEDICAL CERTIFICATION <u>Cancer Prostate gland</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <u>177X</u>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>518</u>			
(a) <u>518</u>			
(b) _____			
(c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
m.		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 19..... to 19....., that I last saw the deceased alive on 19....., and that death occurred at 10:30A.M., from the causes and on the date stated above. SIGNATURE <u>Aug 11 1951</u> (Degree or title) <u>Physician & Surgeon</u> ADDRESS <u>Bozman, Md.</u> DATE SIGNED <u>July 1951</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <u>June 20, 1951</u>	
NAME OF CEMETERY OR CREMATORIAL <u>Bozman Cemetery</u>		LOCATION (City, town, or county) <u>Bozman, Md.</u>	
(State)			
DATE REC'D BY LOCAL REG. #		REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR		ADDRESS	
<u>June 19-51</u>		<u>L. Wesley Sevell</u>	
Newman & Harrison, St. Michaels		Md.	
		100105	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 25 1951

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06322

Reg. Dist. No. 290

VS. A. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY Talbot		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Easton		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fishing Creek	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital		STREET ADDRESS (none)	
3. NAME OF DECEASED (Type or Print)	(First) CLARA	(Middle) TRAVERS	(Last) SIMMONS
4. DATE OF DEATH	JUNE 12	(Month)	(Year) 1951
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH 1-2-1885
9. AGE last birthday 66 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Edward Travers	14. MOTHER'S MAIDEN NAME Ida Bell Dorr	15. WAS DECRAFTED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT AND ADDRESS Mrs. Edward Simmons - Fishing Creek, Maryland	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH 3 months
Immediate cause 415X		(a) Myocarditis	
Antecedent cause(s) 93c		(b) Pneumonia and stating the underlying cause last	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at m. Not While Work At work	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from July 1950, to June 12, 1951, that I last saw the deceased alive on June 12, 1951, and that death occurred at 5:50 p.m. from the causes and on the date stated above. SIGNATURE: (Degree or title) ADDRESS: DATE SIGNED M. V. Palmer M.D. Easton, Maryland 6/13/51			
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 6-14-1951	NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) Hoosier Memorial Cemetery-Fishing Creek, Md.	(State)
DATE REC'D. BY LOCAL REG.	REGISTRAR'S SIGNATURE H. Neerue	24. FUNERAL DIRECTOR LeCompte Funeral Service,	ADDRESS
Cambridge, Maryland			

RECEIVED

JUN 19 1951

BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06323

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH CITY COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Mo</i>		CITY COUNTY <i>Talbot</i>		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Paul Steppen</i>		LENGTH OF STAY (in this place) <i>25 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Paul Steppen</i>		STREET ADDRESS (If rural, give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS								
3. NAME OF DECEASED (Type or Print)		(First) <i>Clarence</i>	(Middle) <i>Alexander</i>	(Last) <i>Steppen</i>	4. DATE OF DEATH	(Month) <i>June</i>	(Day) <i>28</i>	(Year) <i>1957</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>Oct. 9, 1894</i>	9. AGE last birthday yrs. <i>56</i>	If under 1 year Months <i>0</i>	If under 24 hrs. Days <i>0</i>	If under 24 hrs. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Rent</i>		11. BIRTHPLACE (State or foreign country) <i>Talbot County</i>		12. CITIZEN OF WHAT COUNTRY? <i>M. A.</i>		
13. FATHER'S NAME <i>Alexander Steppen</i>		14. MOTHER'S MAIDEN NAME <i>Annie Scherer Lewis</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-30-8767</i>		17. INFORMANT <i>Mrs. C. A. Steppen</i>				
18. MEDICAL CERTIFICATION <i>Coronary occlusion</i>								
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 Immediate cause (a) Antecedent cause(s) Diseases or conditions, if any, (b) giving rise to the above cause stating the underlying cause last 94a (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>		(CITY OR TOWN)		(COUNTY)		(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED Where at m. Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at c.m., from the causes and on the date stated above. SIGNATURE <i>Louis Mutter M.D. Dme</i> (Degree or title) <i>Easter Md</i> ADDRESS DATE SIGNED <i>6-18-51</i>								
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <i>July 3, 1951</i>		NAME OF CEMETERY OR CREMATORIAL <i>Grady Ave</i>		LOCATION (City, town, or county) <i>Grady Ave</i>		(State) <i>Md</i>
DATE REC'D BY LOCAL REG. <i>6/29/57</i>		REGISTRAR'S SIGNATURE <i>H. H. Nease</i>		24. FUNERAL DIRECTOR <i>Bell Clark</i>		ADDRESS <i>Easter Md</i>		



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06324

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MARYLAND</i> COUNTY <i>Talbot</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Easton</i>		LENGTH OF STAY (in this place) <i>70 days.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>The Memorial Hospital</i>		3. NAME OF DECEASED (First) <i>hulu</i> (Middle) <i>m.</i> (Last) <i>Smith</i>	
4. SEX <i>Female</i>	5. COLOR OR RACE <i>White</i>	6. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Married</i>	7. DATE OF BIRTH <i>1875 May 76</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	9. AGE last birthday If under 1 year Months <i>76</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i> yrs.
13. FATHER'S NAME <i>Mr. William E. Smith</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
16. SOCIAL SECURITY NO. <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Jane Smith</i>	
17. INFORMANT AND ADDRESS <i>Mrs Carrie Smith (Same address)</i>		18. MEDICAL CERTIFICATION <i>Paralysis agitans</i> <i>Arteriosclerosis generalized</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause <i>450.0</i> (a) _____ Antecedent cause(s) <i>81c</i> (b) _____ Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input checked="" type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? ADDRESS
22. I hereby certify that I attended the deceased from <i>6-1-</i> , 1949, to <i>6-1-</i> , 1951, that I last saw the deceased alive on <i>6-1-</i> , 1951, and that death occurred at <i>10:45 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>R. C. Co.</i> ADDRESS <i>Easton Md</i> DATE SIGNED <i>6/2/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>6/3/51</i> NAME OF CEMETERY OR Crematory <i>Spring Hill</i> LOCATION (City, town, or county) <i>Easton Md</i> (State)	
DATE REC'D. BY LOCAL REG. <i>6/2/51</i>		REGISTRAR'S SIGNATURE <i>R. H. Deerey</i> 4. FUNERAL DIRECTOR ADDRESS <i>P. Ellis Clark</i> <i>Easton Md</i>	

RECEIVED
BUREAU V. S.

JUN 7 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06325

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Oxford, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Oxford</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Laurel Street</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Robert</u>	(Middle) <u>R</u>	(Last) <u>Taylor</u>
4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>27</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>April 15, 1918</u>
9. AGE last birthday yrs. <u>33</u>	10. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>	11. BIRTHPLACE (State or foreign country) <u>Princeton, Md</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>Henry D. Taylor</u>	14. MOTHER'S MAIDEN NAME <u>Sedgely Reeder</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>Yes</u> 16. SOCIAL SECURITY NO. <u>W.W.II 216-03-7419</u>	
17. INFORMANT <u>Derby Taylor</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>Accidental drowning</u>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Respiratory Disease</u>			
(a) <u>850.8</u>			
(b) <u>172</u>			
(c) <u></u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? <input type="checkbox"/> Yes <input type="checkbox"/> No			
21. ACCIDENT SUICIDE HOMICIDE <u>Accident</u>	(Specify) <u>injury</u>	PLACE (Home, farm, factory, street, of office bldg., etc.) <u>work</u>	(CITY OR TOWN) <u>Oxford</u> (COUNTY) <u>Talbot</u> (STATE) <u>Md</u>
TIME (Month) <u>6</u>	(Day) <u>28</u>	(Year) <u>1951</u>	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>
INJURY <u>fall from boat - couldn't swim</u>	HOW DID INJURY OCCUR? <u>fall from boat - couldn't swim</u>		
22. I hereby certify that I attended the deceased <u>D.P.M.</u> on <u>19</u> , to <u>19</u> , that I last saw the deceased			
alive on <u>19</u> , and that death occurred at <u>C. G. 35P</u> m., from the causes and on the date stated above. SIGNATURE <u>Louis H. Neerius M.D. D.M.E.</u> ADDRESS <u>Princeton, Md.</u> DATE SIGNED <u>6/28/51</u>			
23. BURIAL, CREMATION REMAINS <u>Burial</u>	DATE THEREOF <u>June 30, 1951</u>	NAME OF CEMETERY OR CREMATORIAL <u>Springfield Cemetery</u>	LOCATION (City, town, or county) <u>Oxford</u> (State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>6/28/51</u>	REGISTRAR'S SIGNATURE <u>N. H. Neerius</u>	24. FUNERAL DIRECTOR <u>Robert Taylor</u>	ADDRESS <u>Oxford, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06326

Reg. Dist. No. 290

CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Easton</i>		LENGTH OF STAY (in this place) <i>9 days</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Easton Memorial Hospital</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Chestertown</i>	
3. NAME OF DECEASED (First) (Type or Print) <i>Eugene</i>		(Middle) <i>Carl</i>	
4. DATE OF DEATH <i>June 9 1957</i>		(Last) <i>Thompson</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>married</i>	8. DATE OF BIRTH <i>March 31, 1901</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Building carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Eugene Thompson</i>		14. MOTHER'S MAIDEN NAME <i>Manuel Lawrence</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Number</i>	
17. INFORMANT AND ADDRESS <i>Adelaide Thompson (Same)</i>		18. MEDICAL CERTIFICATION <i>Cardiac failure, due to coronary thrombosis, Alcoholic cirrhosis</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause <i>581.1</i> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>124a</i> (a) <i>Thrombosis</i> (b) <i>Alcoholic cirrhosis</i> (c) <i>3 years</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) OF INJURY	(Day) m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? DATE SIGNED
22. I hereby certify that I attended the deceased from <i>June 9, 1957</i> , to <i>June 9, 1957</i> , that I last saw the deceased alive on <i>June 9, 1957</i> , and that death occurred at <i>11:25 P.m.</i> , from the causes and on the date stated above. SIGNATURE <i>Thompson</i> (Degree or title) <i>Daughter</i> ADDRESS <i>Carson Mayland 10pm 51</i> DATE SIGNED <i>1957</i>			
23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF <i>6/13/57</i>	NAME OF CEMETERY OR CREMATORIAL <i>Stevensonville</i>
DATE REC'D BY LOCAL REG.		REGISTRATION'S SIGNATURE <i>N.B. Neeress</i>	LOCATION (City, town, or county) (State) <i>Stevensonville Md.</i>
24. FUNERAL DIRECTOR ADDRESS		<i>Edgar L. Lane Church Hill and 510246</i>	

RECEIVED
BUREAU V. S.

JUN 19 1951

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06327

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY Talbot			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Colorado		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN nr Trappe			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Denver		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print) Peter Schuyler			4. DATE (Month) (Day) (Year) OF DEATH 6 18 1951		
5. SEX male			6. COLOR OR RACE white		
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)			8. DATE OF BIRTH May 10, 1924		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lt JG US Navy			9. AGE last birthday 27 yrs.		
10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Denver, Colo.		
13. FATHER'S NAME Robert C. Van Schaack			12. CITIZEN OF WHAT COUNTRY U.S.A		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes			16. SOCIAL SECURITY NO. unknown		
17. INFORMANT Lt. JG, Dodge, U. S. N.			18. MEDICAL CERTIFICATION		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		

Immediate cause

(a) Suicide-carbon monoxide poisoning

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last

163M (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY 6 18 '51 Cm. 5PM	INJURY OCCURRED While at Work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? hose from exhaust led into car		

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide homicide , undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county) (State)
Burial, Interment	By U. S. Naval Ambulance Annapolis	1403 67th Street	Home Md.
DATE REC'D BY LOCAL REG. 6/20/51	REG. 7 H. Morris	John D. Williams	29096

RECEIVED

JUN 25 1981

BUREAU K-5